#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/16/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA !DENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	DOLUBED OD GUDDI IEG	435074	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	12/	02/2021
	ROVIDER OR SUPPLIER			1	11 CALUMET AVENUE NW		
GOOD SA	MARITAN SOCIETY DE S	SMET		D	E SMET, SD 57231		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XS) COMPLETION DATE
	REGULATORY OR LESS INITIAL COMMENTS  Surveyor: 06365  A recertification health 42 CFR Part 483, Sul	n survey for compliance with opart B, requirements for ties, was conducted from 2/21. Good Samaritan	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
		EDEMION	20		ADMINIST PLATOR  20 DEC 200	· l	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEC 2 0 2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
,		435074	B. WING		12/02	2/2021
	ROVIDER OR SUPPLIER  MARITAN SOCIETY DE S	SMET	4	STREET ADDRESS, CITY, STATE, ZIP CODE 111 CALUMET AVENUE NW DE SMET, SD 57231		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	- 1	(X5) COMPLETION DATE
E 000	CFR Part 482, Subpa Emergency Prepared Term Care Facilities, 11/30/21 through 12/2 Society De Smet was with the following required Development of EP PCFR(s): 483.73(b)  \$403.748(b), \$416.54 \$441.184(b), \$460.84 \$483.475(b), \$485.625(b), \$485.72 \$486.360(b), \$491.12  (b) Policies and procedure policies and procedure pand implement policies and procedure policies at paragrand the communication this section. The policies policies policies policies and update this section. The policies policies policies and update policies policies policies at procedures, based on forth in paragraph (a) assessment at paragrand the communication this section. The policies policies policies and update policies polic	found not in compliance uirements: E013, and E039. olicies and Procedures  (b), §418.113(b), (b), §482.15(b), §483.73(b), 2(b), §485.68(b), 7(b), §485.920(b), (b), §494.62(b).  dures. [Facilities] must nt emergency preparedness es, based on the emergency raph (a) of this section, risk aph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must atted at least every 2 years. §483.73(b):] Policies and facility must develop and or preparedness policies and the emergency plan set of this section, risk aph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must	E 000 E 013		itute an eler of the nes set The plan uted ovisions oses of ponse center's ewith Manual.	0 Dec 2021
ABODATODY		UPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(XE	6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete DE C 3 U Z Event ID: QLPM11

Facility ID: 0094

If continuation sheet Page 1 of 13

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		435074	B. WING_		12/0	02/2021
	ROVIDER OR SUPPLIER	SMET		STREET ADDRESS, CITY, STATE, ZIP CODE 411 CALUMET AVENUE NW DE SMET, SD 57231		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
E 013	develop and implement policies and procedure plan set forth in paragand the communication this section. The policies management emergencies, including equipment, power, or emergencies; and nathreaten the health or staff, or the public. To must be reviewed and years.  *[For ESRD Facilities procedures. The dial and implement emergencies and procedures, based and procedures, based set forth in paragraph assessment at paragand the communication this section. The policies emergencies and upd These emergencies in to, fire, equipment or emergencies, water and procedures. This REQUIREMENT by:  Surveyor: 06365  Based on interview a plan review, the facilities	A4(b):] Policies and CE organization must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of icies and procedures must at of medical and nonmedical right not limited to: Fire; water failure; care-related atteral disasters likely to resafety of the participants, the policies and procedures dupdated at least every 2 at \$494.62(b):] Policies and lysis facility must develop gency preparedness policies and of this section, on plan at paragraph (c) of icies and procedures must ated at least every 2 years. Include, but are not limited power failures, care-related supply interruption, and by to occur in the facility's	EOT	By 12 January 2022 Emergency Management updated to include 6 month average daily control to period to be served meals/water or period. In the event resident/staffing numbers adjusted this adjustment will be documented at the EMP. Emergency Services Agreement (E Close Septic Service to have our Cistern drain an interruption in sewer service. Waste dispose) (3) total dumpsters that can be utilized for was which will hold approximately 6 days' worth of event that waste disposal is not an option gree we can store trash double bagged and stored for transport refuse to the local solid waste site 12 January 2022 will educate staff on policylp "sheller in place" scenarios regarding sewer/s On 17 December and 20 December, respectiv Transportation ESA with Wilder House and ES School District was signed and placed in the EAdministrator or designee will perform audit for education, proof of EMP review, and current to agreements. Audits will occur monthly for 3 m Administrator or designee will report findings t Committee monthly. QAPI committee to determonitoring and interventions. Substantial com achieved by 12 January 2022.  Addendum:  Administrator or designee will educate all currupdates to incude sewer/solid waste and transchanges.		12 Jan 2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE COI		(X3) DATE SURVEY COMPLETED		
		435074	B. WNG				12/02/2021	
V)	ROVIDER OR SUPPLIER  MARITAN SOCIETY DE S	SMET		411 C	ET ADDRESS, CITY, STATE, ZIP CODE ALUMET AVENUE NW MET, SD 57231			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
E 013	emergency.  *Maintenance needs an emergency.  *Arrangements with or of services.  This has the potential residing in the facility situation.  Findings include:  1. Review of the facility preparedness plan retenance the all-hazards risk infectious disease out and a procedures the all-hazard identified in t	the facility at risk for an for sheltering in place during ther providers for continuity to affect all residents at the time of an emergency vealed: assessment did not include threak situations. were not included for each erisk assessment. for sheltering in place did vould be served using the good and water. sposal of sewage and ther providers for wage/waste disposal were strator H on 12/2/2021 at should have been included to the number of persons of food and water would be ag in place. It about having a back-up waste disposal during an engements for transportation	E	013				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI		COMPLETED				
		435074	B. WING			12/	02/2021	
	ROVIDER OR SUPPLIER MARITAN SOCIETY DE	SMET	STREET ADDRESS, CITY, STATE, ZIP CODE 411 CALUMET AVENUE NW DE SMET, SD 57231			90		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE .	(X6) COMPLETION DATE	
E 013 E 039 SS=D	agreement. EP Testing Requirer CFR(s): 483.73(d)(2) §416.54(d)(2), §418 §460.84(d)(2), §482 §483.475(d)(2), §484 §485.625(d)(2), §494 *[For ASCs at §416. "Organizations" und §485.920, RHCs/FC Facilities at §494.62 (2) Testing. The [facto test the emergence must do all of the following to the following to the following the facility natural or man-made activation of the emergence must do all of the facility natural or man-made activation of the emergence must do all of the facility natural or man-made activation of the emergence munity-based or functional exercise factual event.	nents ) .113(d)(2), §441.184(d)(2), .15(d)(2), §483.73(d)(2), 4.102(d)(2), §485.68(d)(2), 5.727(d)(2), §485.920(d)(2), .62(d)(2).  54, CORFs at §485.68, OPO, er §485.727, CMHCs at tHCs at §491.12, and ESRD ]: ility] must conduct exercises by plan annually. The [facility] llowing:  II-scale exercise that is every 2 years; or nity-based exercise is not a facility-based functional		013	By 12 January 2022 Safety Committee will complet Tabletop drill to ensure compliance with regulations ensure ALL tabletop exercises are documented and the EMP Binder for easy access. Tomado Drills will completed annually with cooperation with the Kings Emergency Manager during statewide drill. Commistered and drill is correctly documented. Staff participation will be encouraged with staff education to follow the ensure understanding. Administrator or designee wards for completion of table top exercise, staff education of a months. Administrator or designee will report if QAPI Committee monthly. QAPI committee to dete ongoing monitoring and interventions. Substantial owill be achieved by 12 January 2022.  ADDENDUM:  Administrator or designee will educate all current strabletop drill exercise time/location and results/findi		12 Jan 2022	
	functional exercise this section is condunot limited to the foll (A) A second full-sea	•						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		435074	B. WNG	-		12/	02/2021
×	ROVIDER OR SUPPLIER  MARITAN SOCIETY DE S	MET		STREET ADDRESS, CITY, STATE, 2 411 CALUMET AVENUE NW DE SMET, SD 57231	JP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE. CROSS-REFERENCED DEFICE	ACTION SHOULD BE TO THE APPROPRIAT		(X5) COMPLETION DATE
E 039	functional exercise; or (B) A mock disaster di (C) A tabletop exercis a facilitator and includ a narrated, clinically-rescenario, and a set of directed messages, or designed to challenge (iii) Analyze the [facilit maintain documentative exercises, and emergifacility's] emergency (For Hospices at 418 (2) Testing for hospice patient's home. The hexercises to test the eannually. The hospice (i) Participate in a full-community based eve (A) When a community accessible, conduct at functional exercise eve (B) If the hospice experimentally and emergency plan, the emergency onset of the emergency onset of the emergency of the emergency of the emergency plan, the emergency plan, the emergency plan is next recommunity-based exercise under paragris conducted, that may to the following:  (A) A second full-scale (B) A s	rill; or e or workshop that is led by es a group discussion using elevant emergency problem statements, reprepared questions an emergency plan. y's] response to and on of all drills, tabletop ency events, and revise the olan, as needed.  113(d):] es that provide care in the cospice must conduct mergency plan at least e must do the following: escale exercise that is ry 2 years; or y based exercise is not in individual facility based ery 2 years; or eriences a natural or of that requires activation of the hospital is exempt from quired full scale rcise or individual al exercise following the exy event. onal exercise every 2 years, full-scale or functional aph (d)(2)(i) of this section of include, but is not limited	E	039			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		435074	B. WING_	_		12/	02/2021
	ROVIDER OR SUPPLIER  MARITAN SOCIETY DE S	SMET		4	TREET ADDRESS, CITY, STATE, ZIP CODE 11 CALUMET AVENUE NW IE SMET, SD 57231		
(X4) ID PREFIX TAG			PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	a facilitator and include a narrated, clinically-recent and a set of directed messages, or designed to challenge (3) Testing for hospical care directly. The hospical care directly. The hospical care directly. The hospical care directly. The hospical management of the exercises to test the expear. The hospical management is community-based; (A) When a community-based; (A) When a community-based function (B) If the hospical expension of the emergency plan, the emergency plan is not community-based or a exercise; or (B) A mock disaster of (C) A tabletop exercise; or (B) A mock disaster of (C) A tabletop exercise facilitator that includes narrated, clinically-reliand a set of problem is messages, or prepare challenge an emerger (iii) Analyze the hosp maintain documentating and the problem is the problem in the problem in the problem is the problem in the problem in the problem is the problem in the problem is the problem in th	drill; or se or workshop that is led by les a group discussion using elevant emergency f problem statements, r prepared questions e an emergency plan.  es that provide inpatient spice must conduct emergency plan twice per just do the following: nnual full-scale exercise that or ty-based exercise is not en annual individual hal exercise; or eriences a natural or y that requires activation of the hospice is exempt from equired full-scale community d functional exercise the emergency event. onal annual exercise that of limited to the following: le exercise that is a facility based functional drill; or se or workshop led by a s a group discussion using a evant emergency scenario, statements, directed ed questions designed to ncy plan.	E	039			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		435074	B. WING	_		12/02/2021	
	ROVIDER OR SUPPLIER  MARITAN SOCIETY DE S	SMET		4	TREET ADDRESS, CITY, STATE, ZIP CODE 11 CALUMET AVENUE NW E SMET, SD 57231		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE
E 039	Continued From page hospice's emergency		E	39			
	conduct exercises to twice per year. The [ do the following: (i) Participate in an a is community-based; (A) When a community accessible, conduct a facility-based function (B) If the [PRTF, Hospactual natural or manrequires activation of [facility] is exempt from required full-scale confacility-based function onset of the emergency (ii) Conduct an [a and that may include, following: (A) A second full-scale community-based or infunctional exercise; or (B) A mock of (C) A tabletop except discussion, using a nate of the emergency scenario, statements, directed in questions designed to plan.  (iii) Analyze the [imaintain documentation and community that is plan.	§485.625(d):] F, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must nnual full-scale exercise that or ty-based exercise is not n annual individual, nal exercise; or oital, CAH] experiences an made emergency that the emergency plan, the m engaging in its next nmunity based or individual, nal exercise following the cy event. additional] annual exercise or but is not limited to the lie exercise that is ndividual, a facility-based r lisaster drill; or ercise or workshop that is I includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency facility's] response to and on of all drills, tabletop					
	(C) A tabletop excled by a facilitator and discussion, using a nate emergency scenario, statements, directed requestions designed to plan.  (iii) Analyze the [Imaintain documentations of the companion of the co	ercise or workshop that is I includes a group arrated, clinically-relevant and a set of problem nessages, or prepared o challenge an emergency facility's] response to and					a 22

	ND DI AN OF CORRECTION INDESTRUCTION NUMBERS		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		435074	B, WNG_	-		12/	02/2021
	ROVIDER OR SUPPLIER  MARITAN SOCIETY DE S	SMET		41	REET ADDRESS, CITY, STATE, ZIP CODE 1 CALUMET AVENUE NW E SMET, SD 57231		,
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X8) COMPLETION DATE
E 039	[facility's] emergency  *[For PACE at §460.8 (2) Testing. The PACE exercises to test the eannually. The PACE of following: (i) Participate in an anis community-based; (A) When a community accessible, conduct a facility-based function (B) If the PACE experman-made emergency plan, the emergency plan, the emergency plan, the emergency plan, the exercise following the event.  (ii) Conduct an acceptance of the emergency plan, the exercise following the event.  (iii) Conduct an acceptance of the exercise under paraging is conducted that may the following: (A) A second full-scal community-based or infunctional exercise; or (B) A mock disaster of (C) A tabletop exercise a facilitator and including a narrated, cliniscenario, and a set of directed messages, or designed to challenge (iii) Analyze the PACI maintain documentation.	plan, as needed.  4(d):] E organization must conduct emergency plan at least organization must do the must full-scale exercise that or ty-based exercise is not annual individual, all exercise; or iences an actual natural or y that requires activation of the PACE is exempt from equired full-scale community acility-based functional onset of the emergency diditional exercise every 2 ar the full-scale or functional raph (d)(2)(i) of this section or include, but is not limited to the exercise that is individual, a facility based full; or see or workshop that is led by les a group discussion, cally-relevant emergency problem statements, or prepared questions an emergency plan. E's response to and on of all drills, tabletop ency events and revise the	, E (	039			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY
		435074	B. WNG			12/	02/2021
	ROVIDER OR SUPPLIER  MARITAN SOCIETY DE S	SMET		4	STREET ADDRESS, CITY, STATE, ZIP CODE 111 CALUMET AVENUE NW DE SMET, SD 57231		
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E 039	test the emergency plincluding unannounce emergency procedure ICF/IID] must do the final is community-based; (A) When a community accessible, conduct at facility-based function (B) If the [LTC facility] actual natural or manrequires activation of the LTC facility is exempt required a full-scale of individual, facility-based following the onset of (ii) Conduct an additional include, but is not (A) A second full-scale community-based or a functional exercise; or (B) A mock disaster of (C) A tabletop exercise a facilitator includes a narrated, clinically-releand a set of problems messages, or prepare challenge an emergen (iii) Analyze the [LTC and maintain documer exercises, and emerge [LTC facility] facility's exercises.  *[For ICF/IIDs at §483.]	§483.73(d):] nust conduct exercises to an at least twice per year, ad staff drills using the es. The [LTC facility, collowing: nnual full-scale exercise that for ey-based exercise is not annual individual, all exercise.  facility experiences an emade emergency plan, the from engaging its next community-based or ed functional exercise the emergency event. In all annual exercise that it limited to the following: e exercise that is an individual, facility based event emergency scenario, statements, directed difference questions designed to exercise the emergency scenario, statements, directed diffusions designed to exercise the emergency scenario, statements, directed diffusions designed to exercise the emergency scenario, statements, directed diffusions designed to exercise the emergency plan, as needed.	E	039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION		(X3) DATE SURVEY COMPLETED		
		435074	B. WING	·		12/	02/2021		
	ROVIDER OR SUPPLIER  MARITAN SOCIETY DE S	SMET		411 C	ET ADDRESS, CITY, STATE, ZIP CODE ALUMET AVENUE NW MET, SD 57231	•	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
E 039	The ICF/IID must do (i) Participate in an aris community-based; (A) When a community accessible, conduct a facility-based function (B) If the ICF/IID experimental emergency plan, the emergency event.  (ii) Conduct an additional exercise for emergency event.  (ii) Conduct an additional exercise; of (A) A second full-scal community-based or functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator and includusing a narrated, cliniscenario, and a set of directed messages, of designed to challenge (iii) Analyze the ICF/III maintain documentaticexercises, and emerging ICF/IID's emergency exercises and emergency least annually. The Histo test the emergency least annually. The History based; or	plan at least twice per year. the following: nrual full-scale exercise that or ty-based exercise is not annual individual, all exercise; or. eriences an actual natural or y that requires activation of the ICF/IID is exempt from equired full-scale individual, facility-based illowing the onset of the onal annual exercise that at limited to the following: e exercise that is an individual, facility-based or rill; or e or workshop that is led by les a group discussion, cally-relevant emergency i problem statements, or prepared questions e an emergency plan. D's response to and on of all drills, tabletop ency events, and revise the plan, as needed.  O2] HA must conduct exercises or plan at HA must do the following: escale exercise that is	E	039					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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E 039	or.  (B) If the HHA exor man-made emerge of the emergency plar engaging in its next recommunity-based or infunctional exercise fol emergency event.  (ii) Conduct an addition opposite the year the exercise under paragris conducted, that limited to the following (A) A second full-community-based or a functional exercise; or (B) A mock disast (C) A tabletop exelled by a facilitator and discussion, using a nate emergency scenario, a statements, directed in questions designed to plan.  (iii) Analyze the HHA's documentation of all demergency events, an emergency plan, as new ferone in the option of the	n annual individual, all exercise every 2 years; experiences an actual natural ncy that requires activation in, the HHA is exempt from equired full-scale individual, facility based lowing the onset of the enal exercise every 2 years, full-scale in or functional each (d)(2)(i) of this section emay include, but is not exercise that is an individual, facility-based er drill; or ercise or workshop that is includes a group errated, clinically-relevant and a set of problem essages, or prepared challenge an emergency exercises, and direvise the HHA's eeded.	E	039			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY DE SMET				4	TREET ADDRESS, CITY, STATE, ZIP CODE 11 CALUMET AVENUE NW DE SMET, SD 57231		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	emergency scenario, statements, directed a questions designed to plan. If the OPO experman-made emergency plan, engaging in its next refollowing the onset of (ii) Analyze the OPO'documentation of all demergency events, a OPO's] emergency plan.  *[RNCHIs at §403.74 (d)(2) Testing. The Riexercises to test the emust do the following (i) Conduct a paper-bleast annually. A table discussion led by a factinically-relevant emof problem statement prepared questions demergency plan.  (ii) Analyze the RNHO maintain documentat and emergency plan, as r This REQUIREMENT by:  Surveyor: 06365  Based on interview a plan review, the provi	arrated, clinically relevant and a set of problem messages, or prepared or challenge an emergency ariences an actual natural or by that requires activation of the OPO is exempt from equired testing exercise of the emergency event. It is response to and maintain teabletop exercises, and and revise the [RNHCl's and and, as needed.  188]:  NHCl must conduct emergency plan. The RNHCl is assed, tabletop exercise at each exercise is a group actilitator, using a narrated, ergency scenario, and a set is, directed messages, or esigned to challenge an of all tabletop exercises, its, and revise the RNHCl's needed.  188]:  188]:  188]:  188]:  188]:  188]:  188]:  189]:  180]:  181]:  181]:  181]:  181]:  181]:  182]:  183]:  184]:  185]:  186]:  186]:  187]:  186]:  187]:  188]:	E	039			

STATEMENT C	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION (X3) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION (X3) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION (X3) PROVIDER/SUPPLIER/CLIA (X4) MULTIPLE CONSTRUCTION PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X5) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLI			(X3) DATE COMP	SURVEY LETED		
		435074	B. WNG			12/	02/2021
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY DE SMET				41	REET ADDRESS, CITY, STATE, ZIP CODE 1 CALUMET AVENUE NW E SMET, SD 57231	24	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	administrator H reveal emergency prepared failed to document the *Implementation of era COVID outbreak in *Participation with local partners during two to summer of 2021.	sied they had completed two ness tests during 2021, but ose tests, including: mergency procedures during September 2021. al and county response ornado drills during the played in the emergency where documentation would	Ε	039			·

	A

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/16/2021 FORM APPROVED OMB NO. 0938-0391

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093						
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUC <sup>*</sup> ING <b>01 - MAIN BU</b> I		(X3) DATE SURVEY COMPLETED	
		435074	B. WING	B. WING			/30/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDR	ESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY DE	SMET		411 CALUMET DE SMET, S	T AVENUE NW D 57231		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTE ACTION SHOUNDS FROM THE APPROPRIECT OF T	JLD BE	(X5) COMPLETION DATE
K 000	Life Safety Code (LSi occupancy) was cond Samaritan Society De	ey for compliance with the C) (2012 existing health care ducted on 11/30/21. Good e Smet was found in FR 483.70 (a) requirements	К	000	DMINI STPAT	re).	
LABORATORY	I DIRECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATU	JRE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QLPM21

Facility ID: 0094

South Dakota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED	
		10614	B. WING		12/02/2021	
NAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	ATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY DE S	SMET	UMET AVE NW T, SD 57231			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
\$ 000	Compliance/Noncomp	pliance Statement	S 000	DISCLAIMER:		
S 210	44:73, Nursing Faciliti 11/30/21 through 12/2	of South Dakota, Article les, was conducted from 12/21. Good Samaritan found not in compliance uirement: S210.	S 210	Preparation and execution of this respon- plan of correction does not constitute an or agreement by the provider of the truth facts alleged or conclusions set forth in t statement of deficiencies. The plan of co- prepared and/or executed solely becaus required by the provisions of federal and For the purposes of any allegation that it is not in substantial compliance with fede requirements of participation, this respon- plan of correction constitutes the center's of compliance in accordance with section the State Operations Manual.	admission of the he rrection is e it is state law. he center eral hse and s allegation	
	personnel shall be ever professional for freedocommunicable disease others before assignated days after employment of previous vaccination. The facility may not all communicable disease.	ction of the residents. All aluated by a licensed health om from reportable e which poses a threat to ment to duties or within 14 ht including an assessment and tuberculin skin tests. Illow anyone with a le, during the period of ork in a capacity that would		By 12 January 2022 will educate staff in orientation as well as Staff Developmen that all new hire Health Questionnaires review and signature by an RN. DON/Administrator will review all new h paperwork to include the Health Questic ensure RN review and signature. Admir designee will perform monthly audits of questionnaires for all new hires. Audits monthly for 3 months. Administrator or will report findings to QAPI Committee. committee to determine ongoing monito interventions. Substantial compliance wachieved by 12 January 2022.	t/IP RN will require ire onnaire to histrator or health will occur designee QAP1 ring and	
	absent from duty beca communicable diseas health of residents an return to duty until the physician or physician assistant, nurse pract	ause of a reportable be which may endanger the d fellow employees may not by are determined by a l's designee, physician itioner, or clinical nurse have the disease in a		Administrator or designee will educat involved in New Hire Orientation on requiring RN screening/signature of H Questionnaires. Staff RN will evaluat all New Hire Health Questionnaires. will be updated to reflect RN evaluationsignature requirements.	changes Health 12 Jan 2022 te/sign Procedure	
	met as evidenced by: Surveyor: 32332 Based on employee fi policy review, the pro- of five newly hired em	le review, interview, and vider failed to evaluate four ployees (A, B, D, and E) for e by a licensed health		Jeremiah J. Schne Administrator	ider 30 Dec 2021	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DAT

DEC 3 0 2021

South Dakota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING: \_ B. WING 12/02/2021 10614 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 411 CALUMET AVE NW GOOD SAMARITAN SOCIETY DE SMET **DE SMET, SD 57231** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 210 S 210 Continued From page 1 employment. Findings include: 1. Review of five employee Medical History Questionnaires revealed: \*Certified nursing assistant (CNA) C had a hired date on 12/22/20. -Her medical questionnaire had been reviewed and signed by registered nurse (RN) G. \*Cook A had been hired on 9/14/21. -His medical questionnaire had been reviewed and signed by business manager F. \*Director of nursing services (DNS) B had a hired date of 6/7/21. -His medical questionnaire had been reviewed and signed by business manager F. \*RN D had a hired date of 11/16/21. -Her medical questionnaire had been reviewed and signed by business manager F. \*Environmental services employee E had a hired date of 8/4/21. -His medical questionnaire had been reviewed and signed by business manager F. Review of a blank medical history questionnaire form revealed the conditional employee was to have answered medical history questions including whether the employee was: -Free of communicable diseases. -Currently free of any contagious diseases that could put the residents at risk. The signature page indicated the human resources representative or designee was to have reviewed and signed the form. Interview on 12/2/21 at 3:30 p.m. with administrator H regarding business manager F reviewing medical histories revealed neither administrator H nor DNS B were aware the questionnaire was to have been reviewed by a

medical professional.

PRINTED: 12/16/2021 FORM APPROVED

South Dakota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED	
		10614	B. WING		12	/02/2021	
	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  411 CALUMET AVE NW  DE SMET, SD 57231						
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD PROVIDE ACTION SH		(X5) COMPLETE DATE	
S 210	*The form was to have employee beginning *All health concerns addressed immediate *Only if there were concerns approvisor, manager representative the concerns.	er's updated February 2019 e policy revealed: ve been reviewed prior to the work. were to have been	\$ 210				